Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE
Revised

House Bill 443 (The Speaker, *et al.*) (By Request - Administration)
Health and Government Operations Finance

Maryland Health Benefit Exchange Act of 2012

This Administration bill expands the operating structure of the Maryland Health Benefit Exchange by, among other things, authorizing the exchange to contract with health insurance carriers in a certain manner, establishing the framework for the Small Business Health Options Program (SHOP) Exchange, and establishing navigator programs for the SHOP and Individual exchanges. The bill requires SHOP Exchange navigators to be licensed, Individual Exchange navigators to be certified, and insurance producers to be authorized to sell qualified plans in the SHOP and/or Individual exchanges. The bill also establishes a process for selecting the benchmark plan that will serve as the standard for the essential health benefits for health benefit plans offered in the small group and individual markets, both inside and outside the exchange.

The bill takes effect June 1, 2012, although some provisions do not take effect until January 1, 2014.

Fiscal Summary

State Effect: Special fund expenditures increase for the Maryland Insurance Administration beginning in FY 2013 to begin licensure of SHOP Exchange navigators. These expenditures cannot be offset by fee revenue under the bill as there is no specific authorization to charge a fee. The bill's penalty provisions are not expected to materially affect State finances. The bill alters the operating structure of the Maryland Health Benefit Exchange but does not require additional expenditures for the exchange. The exchange is currently and will continue to be funded almost exclusively with federal grants through FY 2014. The Governor's proposed FY 2013 budget includes $26.5 million for the exchange.

Local Effect: None.

Small Business Effect: The Administration has determined that this bill has a meaningful impact on small business (attached). Legislative Services concurs with this assessment. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary: The bill establishes requirements for insurance carriers that want to participate in the individual and small group health insurance markets, with separate provisions for "grandfathered" health plans and health plans that are *not* grandfathered health plans.

With respect to health benefit plans that are *not* grandfathered and are issued, delivered, or renewed on or after January 1, 2014, carriers with at least $20.0 million in total aggregate annual earned premium may not offer health benefit plans in the small group market unless they also offer qualified health plans (QHPs) in the SHOP Exchange. Carriers with at least $10.0 million in total aggregate annual earned premium may not offer individual health benefit plans in the State unless they also offer QHPs in the Individual Exchange; any carrier that offers a catastrophic plan also must offer at least one such plan in the exchange. Carriers with total aggregate annual earned premiums less than these amounts may qualify for an exemption as determined by the Insurance Commissioner. The Commissioner, in consultation with the exchange, may assess the impact of the exemptions and alter the exemptions by regulation.

The bill also establishes separate risk adjustment requirements. For plans that are *not* grandfathered, carriers must use a rating methodology based on the experience of all risks covered under the plan. Rates may only vary by whether the plan covers an individual or family, rating area, age, and tobacco use. Current rating requirements remain applicable to grandfathered health plans.

Beginning January 1, 2014, the exchange must allow any qualified plans that meet minimum standards to be offered in the exchange. The exchange may establish minimum standards for qualified plans beyond those required by the federal Patient Protection and Affordable Care Act (ACA).

Beginning January 1, 2016, the exchange may also employ alternative contracting options and active purchasing strategies. Before employing such an option or strategy, the exchange must submit a plan to specified committees of the General Assembly and allow the committees 90 days for review and comment.

The exchange is authorized to enter into agreements or memoranda of understanding with other states to develop joint or reciprocal certification processes, develop consistency in qualified plans offered across states, and coordinate administrative resources.

The exchange may require a health benefit plan, in order to be certified as a QHP, to (1) include transition of care language in contracts; (2) meet criteria that encourage and support QHPs in facilitating cross-border enrollment; and (3) demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act of 2008.

Uncodified language authorizes the Board of Trustees of the Exchange, if necessary to comply with federal law and regulations and allow carriers offering qualified plans sufficient time to design and develop such plans and file rates, to adopt interim policies pending adoption of regulations after receiving specified legislative comment.

Small Business Health Options Program Exchange: The SHOP Exchange must be a separate insurance market within the exchange for small employers and allow qualified employers to designate a coverage level within which their employees may choose any QHP, or designate a carrier or insurance holding company system and a menu of QHPs offered by the carrier or insurance holding company system from which their employees may choose. The SHOP Exchange may allow qualified employers to designate qualified dental plans (QDPs) and qualified vision plans (QVPs). On or after January 1, 2016, the SHOP Exchange may reassess and modify this process. Any modification of offerings and choice must be implemented through regulations adopted by the SHOP Exchange. The SHOP Exchange must develop specified training programs for SHOP Exchange navigators and licensed insurance producers who seek authorization to sell qualified plans in the SHOP Exchange.

SHOP Exchange Navigator Program: The SHOP Exchange Navigator Program must focus outreach efforts and provide health insurance enrollment and eligibility services to small employers that do not offer health insurance to their employees.

The SHOP Exchange Navigator Program, with respect only to qualified plans offered in the SHOP Exchange, must provide comprehensive consumer assistance services, including conducting education and outreach to small employers; distributing information about the SHOP Exchange; facilitating qualified plan selection, application processes, enrollment, renewals, and disenrollment; conducting eligibility determinations and redeterminations for tax credits; providing referrals; providing information and services in a culturally and linguistically appropriate and accessible manner; and providing specified ongoing support.

A SHOP Exchange navigator must hold a SHOP Exchange navigator license, be engaged by and receive compensation only through the SHOP Exchange, and complete and comply with specified training requirements. A SHOP Exchange navigator may not receive compensation from or otherwise be affiliated with any person connected to the insurance industry. The exchange may not require a SHOP Exchange navigator to hold an insurance producer license.

With respect to the insurance market outside of the exchange, a SHOP Exchange navigator may not provide any information or services related to health benefit plans or other products not offered in the exchange, with the exception of general information provided in a specified consumer education document. A SHOP Exchange navigator may not seek to replace any health benefit plan already offered by a small employer unless the small employer is eligible for a tax credit only through the SHOP Exchange. A SHOP Exchange navigator must refer any inquiries about (1) health benefit plans or other products not offered in the exchange to any resources maintained by the exchange or carriers and licensed insurance producers; and (2) information or services related to qualified plans offered in the Individual Exchange or Medicaid or the Maryland Children's Health Program (MCHP) to the Individual Exchange Navigator Program. A carrier is not responsible for the activities and conduct of a SHOP Exchange navigator.

SHOP Exchange Navigator License: To qualify for a SHOP Exchange navigator license, an applicant must be of good character and trustworthy, be at least 18 years old, pass a specified written examination, and have not committed any act that the Commissioner finds would warrant suspension or revocation of a license.

The Commissioner may suspend, revoke, or refuse to renew or reinstate a SHOP Exchange navigator license under specified circumstances after notice and opportunity for a hearing. Instead of or in addition to suspending or revoking a license, the Commissioner may impose a penalty of at least $100 and as much as $500 for each violation and require that financial restitution be made. The Commissioner must notify the SHOP Exchange of any decision affecting the license of a SHOP Exchange navigator or any sanction imposed on a SHOP Exchange navigator. The Commissioner, as a member of the exchange board, may not participate in any matter that involves the SHOP Exchange Navigator Program if it would create a conflict of interest.

Insurance Producer Authorization Program for the SHOP Exchange: To sell qualified plans in the SHOP Exchange, an insurance producer must register and apply for an authorization from the SHOP Exchange, complete and comply with any specified training requirements, and inform small employers of all QHPs available in the SHOP Exchange and all options available to the small employer in the SHOP Exchange for offering QHPs to employees. Authorization must be renewed every two years. An insurance producer may not be compensated by the SHOP Exchange for the sale of a qualified plan in the SHOP Exchange but must be compensated directly by a carrier. The SHOP Exchange

may suspend, revoke, or refuse to renew an authorization for good cause and must notify the Commissioner of any decision affecting the status of an insurance producer's authorization.

Navigator Program for the Individual Exchange: The Navigator Program for the Individual Exchange must focus outreach efforts and services on individuals without health insurance coverage; use specified Individual Exchange navigator entities; and enable the Individual Exchange to comply with ACA by providing seamless entry into and transition among Medicaid, MCHP, and qualified plans. The program must be administered by the Individual Exchange and regulated by the Commissioner. The Individual Exchange must consult with the Commissioner and the Department of Health and Mental Hygiene (DHMH) to ensure consistency with specified laws, regulations, and policies.

The program must provide comprehensive consumer assistance services, including conducting education and outreach; distributing specified information; facilitating selection of qualified plans, assessment of tax implications and premium and cost-sharing requirements, and application, enrollment, renewal, and disenrollment processes; facilitating eligibility determinations; conducting eligibility determinations and redeterminations for premium subsidies and cost-sharing assistance; providing referrals; providing information and services in a culturally and linguistically appropriate and accessible manner; and providing specified ongoing support.

The Commissioner may require the Individual Exchange to make available all records, documents, data, and other information relating to the Individual Exchange Navigator Program, including the authorization of Individual Exchange navigator entities and the certification of Individual Exchange navigators, and submit a corrective plan to address any problems or deficiencies. The Commissioner, as a member of the exchange board, may not participate in any matter that involves the Individual Exchange Navigator Program if it would create a conflict of interest.

Individual Exchange Navigator Entities: An "Individual Exchange navigator entity" is a community-based organization or other entity or partnership of entities authorized by the Individual Exchange that employs or engages Individual Exchange navigators.

The exchange may authorize an Individual Exchange navigator entity to provide consumer assistance services; limit the authorization of an Individual Exchange navigator entity to the provision of a subset of services; and, pursuant to contractual agreement, require an Individual Exchange navigator entity to provide additional services. An Individual Exchange navigator entity must obtain authorization from the Individual Exchange to provide services that are required to be provided by an Individual Exchange navigator or that result in a consumer's enrollment in Medicaid or MCHP. An Individual Exchange navigator entity may employ or engage individuals other than Individual

Exchange navigators to perform specified activities; must comply with all State and federal laws, regulations, and policies governing Medicaid and MCHP; may not receive compensation from a carrier, an insurance producer, or a third-party administrator in connection with enrollment of a qualified individual in a QHP or a Medicaid managed care organization (MCO) for enrollment of an individual in Medicaid or MCHP; may not provide information or services related to health benefit plans or services not offered in the exchange; and must refer inquiries about health benefit plans or existing health insurance coverage to specified resources or individuals.

The Commissioner may suspend or revoke an Individual Exchange navigator entity authorization after notice and opportunity for a hearing for specified violations. Instead of or in addition to suspending or revoking an Individual Exchange navigator entity authorization, the Commissioner may impose a penalty of at least $100 and up to $500 for each violation and require financial restitution to be made. The Commissioner must notify the Individual Exchange of any decision affecting the authorization of an Individual Exchange navigator entity or any sanction imposed on an Individual Exchange navigator entity. A carrier is not responsible for the activities and conduct of Individual Exchange navigator entities.

Individual Exchange Navigators: Services that involve the sale, solicitation, and negotiation of qualified plans offered in the Individual Exchange must be provided by an Individual Exchange navigator. An Individual Exchange navigator must hold an Individual Exchange navigator certification, be employed or engaged by an Individual Exchange navigator entity, receive compensation only through the Individual Exchange or an Individual Exchange navigator entity, and comply with all laws, regulations, and policies governing Medicaid and MCHP. The exchange may not require an Individual Exchange navigator to hold an insurance producer license.

Individual Exchange Navigator Certification: To qualify for an Individual Exchange navigator certification, an applicant must be of good character and trustworthy, be at least 18 years old, complete and comply with any training requirements, and comply with all applicable requirements of DHMH. Certification must be renewed every two years.

The Commissioner may suspend or revoke an Individual Exchange navigator certification after notice and opportunity for a hearing for specified violations. Instead of or in addition to suspending or revoking a certification, the Commissioner may impose a penalty of at least $100 and up to $500 for each violation and require financial restitution to be made. The Commissioner must notify the Individual Exchange and the Individual Exchange navigator entity for which the Individual Exchange navigator works of any decision affecting the certification of an Individual Exchange navigator or any sanction imposed on an Individual Exchange navigator. A carrier is not responsible for the activities and conduct of Individual Exchange navigators.

Insurance Producer Authorization Process for the Individual Exchange: To sell qualified plans in the Individual Exchange, a licensed insurance producer must have authorization. An insurance producer may not be compensated by the Individual Exchange but must be compensated directly by a carrier. A licensed insurance producer who is authorized to sell, solicit, or negotiate health insurance may sell any qualified plan offered in the Individual Exchange without being separately certified as an Individual Exchange navigator. To do so, an insurance producer must register and apply for an authorization from the exchange, complete and comply with training requirements, and refer individuals seeking insurance who may be eligible for Medicaid or MCHP to the navigator program for the Individual Exchange. The exchange may suspend, revoke, or refuse to renew an authorization for good cause. The Individual Exchange must notify the Commissioner of any decision affecting the status of an insurance producer's authorization.

Qualified Dental Plans: QDPs may be offered by carriers as stand-alone dental plans or as dental plans sold in conjunction with or as an endorsement to QHPs. The exchange may determine whether a carrier may elect to include nonessential oral and dental benefits in a QHP. The bill allows carriers to offer dental benefits through different configurations and authorizes the exchange to determine the standards of disclosure for pricing the benefits. The exchange may exempt QDPs from a requirement applicable to QHPs to the extent the exchange determines the requirement is not relevant to QDPs.

Qualified Vision Plans: The exchange must certify vision plans as QVPs, which can be offered by carriers as stand-alone vision plans or vision plans sold in conjunction with or as an endorsement to QHPs. A carrier offering a QVP must be licensed to offer vision coverage. A QVP must be limited to vision and eye health benefits and include specified minimum benefits. The exchange may determine whether a carrier may elect to include nonessential vision benefits in a QHP. The bill allows carriers to offer vision benefits through different configurations and authorizes the exchange to determine the standards of disclosure for pricing the benefits. A QHP is not required to provide essential benefits that duplicate the minimum benefits of QVPs under specified circumstances. The exchange may exempt QVPs from a requirement applicable to QHPs to the extent the exchange determines the requirement is not relevant to QVPs.

Essential Health Benefits: The State benchmark plan must be selected by the Maryland Health Care Reform Coordinating Council (MHCRCC) through an open, transparent, and inclusive process. Any action of the council may be taken only by the affirmative vote of at least nine members. MHCRCC must establish a mechanism for members of the General Assembly and the public to provide comment and be kept informed by electronic mail. In selecting the State benchmark plan, the council may exclude current required services, benefits, coverage, or reimbursement. The council must obtain guidance necessary to determine the 10 health benefit plans deemed eligible by the U.S. Secretary

of Health and Human Services to be the State benchmark plan, conduct a comparative analysis of the benefits of each plan, solicit the input of stakeholders and the public, and select a plan that complies with all requirements of specified State and federal laws. By September 30, 2012, the council must select the State benchmark plan for coverage beginning January 1, 2014.

Risk Corridors, Transitional Reinsurance, and Risk Adjustment: The exchange may not assume responsibility for the program of risk corridors for health benefit plans in the Individual and SHOP exchanges. In consultation with the Maryland Health Care Commission and with the approval of the Commissioner, the exchange must operate or oversee a transitional reinsurance program for coverage years 2014 through 2016. The exchange, with the approval of the Commissioner, also must operate or oversee a risk adjustment program. Beginning in 2014, the exchange, with the approval of the Commissioner, must strongly consider using the federal model adopted by the U.S. Secretary of Health and Human Services in the operation of the State's risk adjustment program.

Fraud, Waste, and Abuse Detection and Prevention: The exchange must establish a full-scale fraud, waste, and abuse detection and prevention program. However, the exchange must submit a plan for the program to the Senate Finance and House Health and Government Operations committees and allow the committees 60 days for review and comment prior to establishing the program.

Miscellaneous Provisions: MCOs may not be required to offer qualified plans in the exchange. The Exchange Board must submit proposed regulations to specified committees of the General Assembly at least 30 days prior to submitting any proposed regulation to the *Maryland Register* unless this requirement is waived by the committee chairs. The exchange must have at least two standing advisory committees.

Uncodified Study and Reporting Requirements: The bill includes multiple requirements regarding further study and reporting. The bill establishes a joint legislative and executive committee that must, by December 1, 2012, in consultation with specified stakeholders, conduct a study and report its findings and recommendations on the financing mechanisms that should be used to enable the exchange to be self-sustaining by 2015. Among other things, the report must include recommendations on the specific mechanisms that should be used to finance the exchange for consideration by the General Assembly during the 2013 session.

By December 1, 2015, the exchange, in consultation with the Maryland Insurance Administration, must conduct a study and report its findings and recommendations on whether the State should develop a risk adjustment program as an alternative to the federal or Maryland-specific model selected and, if so, how the alternative program

should be designed, when it should be implemented, whether certain strategies should be implemented, and whether the State should develop a Maryland-specific reinsurance program to ensure affordability of premiums in the individual market.

The exchange, in consultation with its advisory committees and other stakeholders, must conduct studies and report its findings and recommendations on:

- the establishment of requirements for continuity of care in the State's health insurance markets (by December 1, 2012);

- whether the exchange should remain an independent public body or should become a nongovernmental, nonprofit entity (by December 1, 2015); and

- whether to continue to maintain separate small group and individual markets or to merge the two markets (by December 1, 2016).

Current Law/Background: To allow individuals to keep the health insurance coverage they already had, ACA "grandfathered" health plans that were in effect on the date the Act was enacted (March 23, 2010) and exempted such plans from many required changes. Grandfathered health plans must adhere to certain consumer protections under ACA, including coverage of dependents up to age 26, a ban on lifetime benefit limits, and a ban on policy rescissions for simple mistakes on an application. Additionally, a grandfathered health plan may not significantly reduce benefits; increase cost sharing; or, for a health benefit plan sponsored by an employer, reduce the employer's share of premiums.

ACA requires each state to establish a health benefit exchange or participate in the federal exchange. By January 1, 2014, exchanges must become operational and offer consumers a choice of plans, establish common rules regarding the offering and pricing of plans, and provide information to help consumers better understand available coverage options.

Chapters 1 and 2 of 2011 established the governance, structure, and funding of the exchange, the primary function of which is to certify and make available QHPs and QDPs to individuals and businesses and to serve as a gateway to an expanded Medicaid program under ACA. Chapters 1 and 2 required the exchange to study and report on (1) the feasibility and desirability of the exchange engaging in selective contracting and multistate or regional contracting within the State; (2) the rules under which health benefit plans should be offered inside and outside the exchange; (3) the design and operation of the exchange's Navigator Program and other consumer assistance mechanisms; (4) the design and operation of the SHOP Exchange; and (5) how the exchange can be self-sustaining by 2015.

The Exchange Board issued a December 2011 report, *Recommendations for a Successful Maryland Health Benefit Exchange*, with recommendations grouped around a series of topics: operating model; market rules and risk mitigation; dental plans; SHOP; Navigator Program; advertising, marketing, and public relations; financing; continuity of care; multi-State and regional contracting; and a plan for fraud, waste, and abuse. Key recommendations included that the exchange should:

- have the flexibility to set minimum standards for QHPs, over and above the requirements of ACA;

- be funded using a broad-based assessment, supplemented by transaction fees tied to enrollment within the exchange;

- be divided into a SHOP Exchange and an Individual Exchange, at least for the first two years;

- have separate navigator programs for the SHOP Exchange and the Individual Exchange;

- require carriers with total premium income above $20 million in the small group market to participate in the SHOP Exchange and carriers with total premium income above $10 million in the individual market to participate in the Individual Exchange;

- limit the SHOP Exchange to employers with 50 or fewer employees prior to 2016 and allow employers to offer their employees either any health plan at a particular metal level (gold, silver, or bronze) or any health plan offered by a single carrier (as is customary in the small group market today);

- certify navigators, who should not be required to have an insurance producer license; and

- provide licensed insurance producers with authorization to sell products within the exchange.

The bill implements most of these recommendations from the exchange report.

Under ACA, beginning January 1, 2014, all health plans offered through an exchange must include certain "essential health benefits." In December 2011, the U.S. Department of Health and Human Services issued a bulletin authorizing the states to choose one of four benchmark plans to meet the requirement for essential health benefits: (1) one of the

three largest small group plans in the state by enrollment; (2) one of the three largest state employee health benefit plans by enrollment; (3) one of the three largest federal employee health benefit plans by enrollment; or (4) the largest insured commercial non-Medicaid health maintenance organization operating in the state. The exchange, with only a week to submit its report to the General Assembly, recommended only that the State choose its benchmark plan by the federal deadline of September 30, 2012.

Additional Comments: The Governor's proposed fiscal 2013 budget includes $26.5 million for the Maryland Health Benefit Exchange and includes nine full-time positions. The exchange has also received three federal grants to date: a $1.0 million planning grant; a $6.2 million Early Innovator Grant; and a $27.2 million Exchange Establishment Grant (Level One Establishment Grant). Maryland is using the grant to conduct policy analysis that will shape the technical and operational infrastructure of the exchange and implement the exchange information technology platform, including product licensing, system integration, and independent verification and validation. The State anticipates applying for a Level Two Establishment Grant before the end of fiscal 2012.

Additional Information

Prior Introductions: None.

Cross File: SB 238 (The President, *et al.*) (By Request - Administration) - Finance.

Information Source(s): Department of Budget and Management, Maryland Health Benefit Exchange, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

Fiscal Note History: First Reader - February 21, 2012
mc/mwc Revised - House Third Reader - April 2, 2012

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510

ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF PROPOSAL: Maryland Health Benefit Exchange Act of 2012

BILL NUMBER: SB 238/HB 443

PREPARED BY: DHMH
(Program\Unit) Office of Governmental Affairs

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

____ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

__x__ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

Include any background information that may help the Department of Legislative Services understand how the agency reached its conclusion.

Senate Bill 238 and House Bill 443 continue development of the operating structure for the Maryland Health Benefit Exchange, created by legislation in the 2011 legislative session. The Exchange will begin offering insurance coverage for individuals and small businesses effective January 1, 2014. The bills authorize the Exchange to contract with health plans in a certain manner; provide a framework for the Small Business Health Options Program (SHOP) Exchange, and establish navigator programs for the Exchange.

The SHOP Exchange framework established in the legislation is designed to provide for viability of the Exchange, increase access to coverage, and provide for predictability for employers as well as employee choice. The SHOP Exchange Navigator Program creates a navigator program to focus outreach to small employers not currently offering insurance.
The bills also provide for the structure of Navigator programs for the Individual Exchange and the SHOP Exchange.

The exact impact on small businesses of the bills is difficult to quantify at this time. However, beginning in 2014, the Exchange will be the only place small businesses will be able to receive tax credits for offering coverage, providing incentives for small businesses who don't offer coverage today.

Additionally, the bills will have a positive impact on small businesses by allowing another venue for small businesses to access affordable insurance coverage. First, employers will now be able to offer employees a choice of carriers in the market as opposed to being required to offer only one carrier. Second, by setting a framework for navigator programs for the Exchange, the Exchange will focus outreach to groups in a culturally and linguistically appropriate manner who have not historically offered coverage, such as in hard to reach areas of the state. The provisions of the bill relating to the operating model of the Exchange are also designed to allow the Exchange to purchase high quality coverage, thereby increasing the value of health benefit plans sold through the Exchange to small businesses.

Finally, it is important to note that the health care market will be infused with approximately $500M in the first year due to subsidies from the federal government for individuals in the Exchange. These subsidies will be in the form of payments for premiums for those in the individual market under 400% of the poverty level (approximately $44,000 for an individual). These individuals who receive new coverage through the Exchange will be utilizing services differently than they have in the past; traditionally, uninsured individuals use the hospital system as their main point of coverage. With new coverage, these individuals will be receiving preventive care, have access to specialists outside the hospital system, will have drug coverage, and other covered services. As a result, small businesses in the healthcare industry will be impacted by more individuals using small business services rather than hospital services.